CHIP
CHILDREN'S HEALTH INSURANCE PROGRAM

The information on this form will help the Utah Department of Health decide if you fit the guidelines for this program.

Applications accepted during open enrollment.

Application Form

Please MAIL this form during an open enrollment period.
CHIP, P.O. Box 144102, Salt Lake City, Utah 84114-4102.

1 Personal Information

Parent/Guardian_____
first middle initial maiden last

Street Address_____
street apt.# city state zip

Mailing Address_____
street apt.# city state zip

Home Phone # (_____) _____ Other Phone # (Cell or Work) (_____) _____

Have any of the children applying for CHIP had large medical expenses in the last 90 days? [ ] Yes [ ] No

Is anyone in your household pregnant or planning to adopt a child in the next 60 days? [ ] Yes [ ] No Due Date: _____

2 Household Information

Start with yourself, then list all the people who live in your home.

Name (First, Middle Initial, Last)	Social Security Number (Optional)	Age	Date of Birth (Mo. Day Year)	Sex (M/F)	Relationship (Spouse, son, etc.)	Race *	Ethnicity *

The children applying for CHIP are: ☐ U.S. citizens ☐ Legal aliens ☐ Other

If legal aliens, please provide alien registration numbers: _____

*Optional – **Race codes:** AI=American Indian or Alaska Native; AS=Asian; BL= Black or African American; PI= Native Hawaiian or other Pacific Islander; WH = White **Ethnicity codes:** H = Hispanic or Latino; N = Not Hispanic or Latino (You may choose more than one race.)

3 Insurance

The following questions are about your children's current insurance:

A. Do any of the household members listed in section 2 have health insurance? [ ] Yes [ ] No If yes, please complete table:

Child's Name	Name of Insurer	Is the insurance employer-sponsored or privately purchased? (Please circle one)
		employer-sponsored / private
		employer-sponsored / private
		employer-sponsored / private

B. Is health insurance available for any household member through work? [ ] Yes [ ] No If yes, please complete table:

Child's Name	Employer's Name	Employer's Phone	Cost (for this child)	How often do you pay

C. Have any household members applying for CHIP had health insurance in the past 90 days? [ ] Yes [ ] No

(If yes, when did coverage end and why?) _____

4 Income

Please list any income received by all the people who live in your home. (Include income from earnings, alimony, social security, unemployment compensation, etc.)

Name of person who received the money	Name of employer or income source	Amount before taxes per pay period	How often paid	# of hours per pay period

I Understand That...

Any and all elements of eligibility listed on this form may be verified. Computer checks will be done when I apply and after I receive benefits. My medical benefits may be reduced, denied, or terminated because of information from these sources.

Knowingly providing false information may result in criminal, civil, or administrative action.

As necessary, the information on this application may be used to determine Medicaid eligibility.

All household members applying for CHIP must be U.S. citizens or aliens in lawful immigration status. I do not have to report citizenship information for household members who are not applying for CHIP. CHIP will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). CHIP will not report undocumented household members to USCIS.

The benefits I receive are limited to those described in the Provider Manual established for this program. I further agree that these manuals may be amended without my consent or consideration.

I may request a fair hearing if I disagree with decisions made regarding this application.

The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete, up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization hotline at 1-800-275-0659.

I must report to CHIP any changes in residence, household size and access to coverage under another health insurance program.

CHIP does not discriminate on the basis of race, ethnicity, religion, sex or disability.

I, _____ swear that the information given on this form is true and correct.

_____

Signature of Applicant Date

Do Not Complete This Section [ ] A [ ] B [ ] M [ ] Denied

_____

Authorized Signature Date

UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 04/14/2003

The Utah Department of Health, Division of Health Care Financing (DHCF) is committed to protecting your medical information. DHCF is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

CONFIDENTIALITY PRACTICES AND USES

DHCF may use your health information for conducting our business. Examples:

Treatment - to appropriately determine approvals or denials of your medical treatment. For example, DHCF health care professionals may review your treatment plan by your health care provider for medical necessity if a Medicaid recipient or for program listed services if a Primary Care Network (PCN) recipient or a Children's Health Insurance Program (CHIP) recipient.

Payment - to determine your eligibility in the Medicaid, PCN or CHIP program and make payment to your health care provider. For example, your health care provider may send claims for payment to DHCF for medical services provided to you, if appropriate.

Health Care Operations - to evaluate the performance of a health plan or a health care provider. For example, DHCF contracts with consultants who review the records of hospitals and other organizations to determine the quality of care you received.

Informational Purposes - to give you helpful information such as health plan choices, program benefit updates, free medical exams and consumer protection information.

YOUR INDIVIDUAL RIGHTS

You have the right to:

Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.

Request that we use a specific telephone number or address to communicate with you.

Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. *

Request corrections or additions to your health information. *

Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*

Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the DHCF Privacy Officer for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid, PCN and CHIP programs and the following:

For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices

To protect victims of abuse, neglect, or domestic violence

For health oversight activities such as investigations, audits, and inspections

For lawsuits and similar proceedings

When otherwise required by law

When requested by law enforcement as required by law or court order

To coroners, medical examiners, and funeral directors

For organ and tissue donation

For research approved by our review process under strict federal guidelines

To reduce or prevent a serious threat to public health and safety

For workers' compensation or other similar programs if you are injured at work

For specialized government functions such as intelligence and national security

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

OUR PRIVACY RESPONSIBILITIES

DHCF is required by law to:

Maintain the privacy of your health information

Provide this notice that describes the ways we may use and share your health information

Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in DHCF offices and on our website, http://health.utah.gov/hipaa. You may also request a copy of any notice from your DHCF Privacy Officer listed below:

CONTACT US

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, Medicaid, PCN and CHIP recipients should contact the DHCF Privacy Officer, Craig Devashrayee, 801-538-6641; 288 North 1460 West, 3rd Floor, PO Box 143102, Salt Lake City, Utah 84114-3102; cdevashrayee@utah.gov.

We will investigate all complaints and will not retaliate against you for filing a complaint.

You may also file a written complaint with the Office of Civil Rights, 200

Independence Avenue, S.W. Room 509F HHH Bldg., Washington, DC 20201